Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: The Plaza at Punchbowl	**CHAPTER 90**
Address: **918 Lunalilo Street, Honolulu, Hawaii 96822**	**Inspection Date: September 18 & 19, 2019 Annual**

THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.

YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-8 Range of services. (a)(1) Service plan. The assisted living facility staff shall conduct a comprehensive assessment of each resident's needs, plan and implement responsive services, maintain and update resident records as needed, and periodically evaluate results of the plan. The plan shall reflect the assessed needs of the resident and resident choices, including resident's level of involvement; support principles of dignity, privacy, choice, individuality, independence, and home-like environment; and shall include significant others who participate in the delivery of services; **FINDINGS** Resident #1- Comprehensive assessment completed on 9/7/19 shows that resident is incontinent, thus resident is at risk for skin breakdown. Resident also had an history of pressure ulcer on 9/14/18 although it healed on 9/29/18. Review of current service plan did not include scheduled skin assessment for resident.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**	

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-8 Range of services. (b)(1)(F) Services. The assisted living facility shall provide the following: Nursing assessment, health monitoring, and routine nursing tasks, including those which may be delegated to unlicensed assistive personnel by a currently licensed registered nurse under the provisions of the state Board of Nursing; **FINDINGS** Resident #1 has an order of timed voiding every eight hours on 1/17/19 due to history of UTI. However, order was not carried out and no documentation that the order was discontinued.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**	

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Licensee's/Administrator's Signature: _____

Print Name: _____

Date: _____